Medicaid Reimbursement for the Female Condom

Susan S. Witte, PhD, Colleen MacPhee, MSW, Natalie Ginsburg, MSW, and Neha Deshmukh, MSW

Objectives. To examine state-level female condom use through Medicaid from 2004 to 2014, because in 2010, the Patient Protection and Affordable Care Act (ACA) allowed for expanded Medicaid coverage in many states, extending requirements for contraceptive care to more of the poorest women in the United States and to most women with private insurance.

Methods. We collected data via brief survey of Medicaid offices in all 50 states between March 2015 and March 2016.

Results. The number of states providing Medicaid reimbursement for the female condom increased 33% (from 25 to 36) since 2007. Twenty-nine states provided data showing low numbers of claims for female condoms but high rates of reimbursement.

Conclusions. This period of heightened access demands that the public health community seize the moment to increase awareness about and promote the female condom among health care professionals and consumers. The pending repeal of the ACA may thwart important gains in access; policies promoting women's reproductive health must be implemented immediately. (*Am J Public Health.* 2017;107:1633–1635. doi:10.2105/AJPH.2017.303936)

In the promotion of women's reproductive health, the prevention of unintended pregnancy and of sexually transmitted infections, including HIV, is a high priority. In 2015, 87% of newly diagnosed HIV infections among women in the United States were from heterosexual transmission,[1] with poor and low-income women disproportionately represented.[2] Although unintended pregnancy has declined overall in the United States over the past 2 decades, it also has become increasingly concentrated among poor and low-income women.[3] Medicaid plays a primary role in facilitating access to reproductive health services and financing health care for poor US women. Women represent approximately 25% of HIV-infected individuals in the United States but 41% of HIV-infected Medicaid beneficiaries.[4,5]

As the only female-initiated barrier method and because gender inequities may deprive women of control over reproductive health decisions, the female condom is an essential option for women. Yet studies consistently report that its rate of use in the United States remains low, and concerns persist about the accessibility of the device.[2]

For more than 2 decades, the female condom has been a reimbursable, over-the-counter device for traditional Medicaid recipients in many states.[6] It also has been available in some states with family planning "expansion programs," addressing low-income women who are not eligible for full-benefit Medicaid. The Patient Protection and Affordable Care Act (ACA; Pub L No. 111–148), passed in 2009 and signed into law in 2010, included 2 changes, 1 associated with Medicaid, that should have increased access to the female condom. First, it gave states the option to expand Medicaid coverage, making contraception more readily available. Second, it required that all contraceptive options approved by the US Food and Drug Administration be covered by insurance providers under preventive services for women at no cost either over the counter or with a prescription.[7] With the ACA expansion, 3 contraceptive coverage pathways for Medicaid-eligible individuals are now available (traditional Medicaid available before the ACA, the Medicaid family planning program, and the ACA Medicaid expansion) within each state. These multiple pathways to coverage have made it difficult to assess whether and where individuals may access the female condom via Medicaid. The only available survey detailing the states' commonalities and differences on contraceptive coverage included 40 states[8] but unfortunately did not ask about the female condom.

We examined state-level access to and use of the female condom through Medicaid from 2004 to 2014, including the years since passage of the ACA. We update data from an earlier survey that examined Medicaid reimbursement for the female condom through 2007.

METHODS

We replicated protocols from our earlier study examining female condom use via Medicaid by state through 2007.[6] Briefly, we collected data by telephone and e-mail, using a script, from each of the 50 state Medicaid offices individually between March 2015 and March 2016.[6] When initial contacts were unable to provide data, we asked for additional contacts from whom we might request data.

We asked the Medicaid representatives 3 questions: (1) How many claims for female condoms have been made by consumers each year from 2004 to 2014?; (2) How many female condom units were distributed in response to these claims?; and (3) What was the total spending in dollars for female

ABOUT THE AUTHORS

At the time of the study, all of the authors were with Columbia University School of Social Work, New York, NY.

Correspondence should be sent to Susan S. Witte, PhD, Columbia University School of Social Work, 1255 Amsterdam Ave, New York, NY 10027 (e-mail: ssw12@columbia.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This brief was accepted May 24, 2017.

doi: 10.2105/AJPH.2017.303936

condoms requested through Medicaid? Contact attempts continued until (1) we obtained data, (2) we were told that the data could not or would not be provided, (3) we were told that the data would require payment in excess of $100, or (4) we were told that the state did not reimburse for the device.

RESULTS

Figure 1 illustrates the Medicaid reimbursement status for the female condom in each state. Of the 50 states, 36 (72%) reported that they currently provide reimbursement. Four states that reported "yes" to reimbursement in 2007 (Arkansas, Florida, Utah, Vermont) and 1 state that we could not contact in 2007 (Delaware) reported that they do not and never did reimburse for the female condom. Nine states reported reimbursement through Medicaid for the first time since 2007[6]: Connecticut, Idaho, Kansas, Kentucky, Maine, New Jersey, Oregon, South Carolina, and Wyoming.

Fourteen states, many in the Southeast, reported that they do not provide Medicaid reimbursement for the female condom. Beginning dates of coverage varied throughout the United States; some states (e.g., Mississippi and Colorado) said that they would begin coverage "soon."

Two additional data tables (available as supplements to the online version of this article at http://www.ajph.org) provide individual and summary data from 29 (81%) of the 36 states reporting reimbursement. Table A shows considerable variance in reporting of data and in claims per year across states. Some states provided comprehensive data across the study period; others reported data for only 1 or 2 years. Some states had thousands of claims, whereas others had few to none. Some states reimbursed hundreds of thousands of dollars, but others reimbursed less than $10 per year. In 2007, Iowa, Michigan, and Nevada showed steady increases in reimbursement, whereas more recent data show increases in some states (Iowa, Oregon, Pennsylvania) but steady decreases in others (Michigan, Minnesota, New York). Claims and reimbursement numbers do not necessarily correspond with relative state-level HIV prevalence or rates of unintended pregnancy.

Table B shows cumulative claims at their highest in 2010, just before ACA passage, and declining after the 2012 contraceptive expansion.

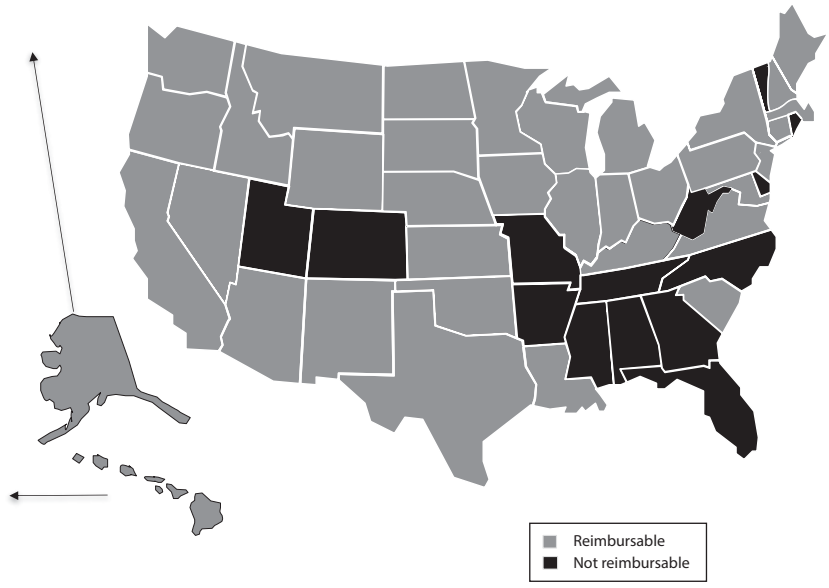

FIGURE 1—State Medicaid Program Reimbursement for the Female Condom: United States, 2014

DISCUSSION

The number of states providing Medicaid reimbursement for the female condom increased 33% (from 25 to 36) since 2007.[6] Findings suggest that the ACA expansion increased access through Medicaid. However, reported use in states providing reimbursement remains uneven, and data collection and reporting challenges persist.

The varying numbers of claims may reflect the unevenness in Medicaid expansion; in 2012, the Supreme Court determined that states could opt out of that expansion. Only in the last 5 to 10 years have many states assigned a unique Medicaid code to distinguish female from male condoms, which affects the count in data searches. A more likely reason is providers' persistent lack of awareness of the device or lack of willingness to recommend or prescribe it or a lack of awareness among consumers about their ability to request it.[2,9]

One interpretive challenge is that utilization data may not accurately reflect claims and costs because some states and programs have an established or negotiated payment to managed care organizations, called capitation, which allows provision of numerous services for 1 annual fee. Therefore, decreases in claims in some states may not reflect fewer distributed female condoms.

PUBLIC HEALTH IMPLICATIONS

The ACA has theoretically increased access to the female condom for most women receiving Medicaid and all women with private insurance free of charge. Getting the device into the hands of women, however, is another matter. This period of heightened access demands that the public health community seize the moment to increase awareness about and promote the female condom among health care professionals and consumers. Apparently, female condoms are seldom claimed or reimbursed through Medicaid. We must spread awareness of the device, promote increases in provider prescriptions, and reduce persistent barriers to its use. Increasing access in states with higher HIV prevalence and unintended pregnancies may contribute to further reductions in the transmission of HIV and other sexually transmitted infections and also reduce

unintended pregnancies. The pending repeal of the ACA may thwart important gains in access; policies promoting women's reproductive health must be implemented immediately. AJPH

CONTRIBUTORS

S. S. Witte conceptualized the study, developed the study protocols, supervised all aspects of the study, collected the data, and led the writing of the article. C. MacPhee, N. Ginsburg, and N. Deshmukh assisted with data collection and with writing and editing of the article.

ACKNOWLEDGMENTS

The authors would like to acknowledge the Medicaid contacts in each state who were willing to take the time to send us data, when available.

HUMAN PARTICIPANT PROTECTION

This study was determined not to include human participants, and therefore no approval was required.

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